# Chapter 1 The basics of performance

## Introduction

This book has been written to help those dental professionals who have struggled with their performance, are struggling, might struggle or are supporting colleagues who are struggling. That is probably just about the whole dental profession at some point in a working career. It will be of use to all categories of dental professional, clinical and non-clinical.

For a number of years, I have worked with dental professionals who have been referred to the General Dental Council (GDC). This has largely been in the capacity of providing advice, coaching or mentoring support to individuals. Over my career, I have worked with and supported dental professionals who have been deemed poor performers. I was instrumental in setting up the National Clinical Assessment Service (NCAS) systems for dentistry and I worked as an Associate Postgraduate Dental Dean supporting dentists in difficulty. I regularly coach or mentor dentists who are facing GDC hearings or local performance procedures. I have also been responsible for developing and implementing training and managing teams of dentists who supported colleagues undertaking programmes of remediation. Before all that, I was a Clinical Director of Community Dental Services for almost 20 years and directly responsible for a large staff and occasionally I had to deal with staff who performed poorly. I'm not the most experienced in these areas, but I consider myself to have a very good knowledge and experience over 30+ years.

All this experience has led me to want to write this book that I hope will help others who come into contact with remediation in whatever guise. Primarily, it provides information that would be helpful should you personally find yourself the subject of a GDC investigation. It will also be of help to those who support professionals under investigation, whether that be with regulation or with an organisation, and here I have called on my experience of developing training programmes for coaches/mentors, educational supervisors, trainers and appraisers. It is my hope that it may also be of interest to dental

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professionals involved in fitness to practise panels. Here, the analysis of how processes affect those individuals referred and the case studies of colleagues may assist in humanising our regulation.

Finally, all dental professionals should find the book of use in the spirit of prevention. It is a sobering thought that any dental professional could be the subject of a GDC referral and investigation at any stage of their career – none of us is immune. During their long careers, dental professionals will interact with many, many patients, and making errors is far more common than is admitted. If you are a dental professional working in a non-clinical field, you can still be referred to the regulator, so you cannot assume that fitness to practise does not apply to you.

I have worked with issues of performance for a number of years both nationally and locally. My input has been strategic in setting up systems and processes, but also operational in that I have personally worked with many dental professionals who find themselves struggling and with a complaint against them, and I still do. My response to performance has always been that any dental professional could find themselves in this position and that few actively seek to perform badly or unprofessionally. Dentistry is a complex profession and the vast majority of dental professionals try every day to do the best work they can for the benefit of others and in the best interests of their patients. Things can go wrong for a wide variety of reasons but in my experience, a proactive, humanistic approach is much more likely to lead to resolution than a punitive reaction. Some dental professionals can find themselves more at risk of struggling and I have included a section on taking a preventive approach in Chapter 7, which includes case studies.

The book will cover reasons why dental professionals get into difficulties; issues of professionalism and underpinning culture and ethics; the regulatory processes and mechanisms within which UK dental professionals work, including the General Dental Council, the Care Quality Commission (CQC) and equivalents in Scotland, Wales and Northern Ireland, and commissioning arrangements. Also included will be information about organisations who work with individuals who struggle; the processes of the GDC when investigating and hearing a complaint; the tools that professionals can use to help them to improve performance; and how self-awareness and insight can be deepened. In addition, I have included some case studies of dental professionals who have first-hand experience of struggling and being involved in fitness to practise processes. Many, if not all of the tools, instruments and mechanisms I have included will be of use to all dental professionals in the course of their day-to-day dental practice. The final chapter considers the skills that supporters of colleagues who struggle need to develop as well as some useful one-to-one techniques.

I firmly believe that the vast majority of dental registrants have no desire to perform at less than their best. I also believe that every one of us has performed poorly during our working careers. We have all had bad days, bad weeks possibly even bad years when our performance has slipped. I'm not suggesting that all dental professionals put patient safety at serious risk but we have all produced work that could be judged as less than the best. We have all exhibited behaviour that we regretted when viewed in hindsight. The reasons for this are many and varied and I will cover those in Chapter 2. In this respect, poorly performing dental professionals are an issue for every one of us; we could all become poor performers and it is something in which we all have a part to play. We all need to be vigilant for colleagues who struggle, not to castigate them, not to point the finger and breathe a sigh of relief that it's them and not us, but to support and help them. We are a caring profession and we should extend that care to each other. If we don't care for our colleagues, how can we really care for our patients? It is not possible to have a dual approach without demonstrating a degree of hypocrisy.

## What is performance?

Before I take a closer look at performance concerns, dips or difficulties, it seems appropriate to first consider what performance is. A good place to begin might be to look at definitions of performance.

**Performance**: 'The execution or fulfilment (of a duty, etc.)'
'The act or process of performing or carrying out'
**To perform**: 'Carry into effect, be the agent of'
(Oxford English Reference Dictionary, 1996)

If performance and performing are about carrying out an act, then for dental professionals that act must be dentistry, in all its forms. The duty that requires execution or fulfilment must be providing dental services for others, most usually patients. So let's take a look at definitions of dentistry:

**Dentistry**: 'The profession or practice of a dentist'

It seems to me that this definition is not very helpful.

**Dentist:** 'A person who is qualified to treat the disease and conditions that affect the mouth, jaws, teeth and their supporting tissues'
(Oxford English Reference Dictionary, 1996)

Whilst this may be a definition of the most recognisable aspect of dentistry, it fails to cover the richness of roles that dental professionals undertake in the broader field of services to patients, the public and society.

Does that bring us any closer to what dental performance is? Probably a little, but it doesn't get to the essence or spirit of what performance actually is, let alone what satisfactory performance, competent performance, acceptable performance, good performance, excellent performance, underperformance or poor performance is. Every act, intervention or conversation undertaken by a dental professional, in the operation of their role, is performed. Each can be judged to be either acceptable or unacceptable. Performance is the essence of dentistry.

The nine principles of *Standards for the Dental Team* (GDC, 2013) set out what dental registrants must do to maintain their registration with the General Dental Council. They are the standards against which all dental professionals are judged. They can be deemed to be our standards of performance. On page 3 of *Standards for the Dental Team*, performance is explicitly noted.

> *'This document sets out the standards of conduct, performance and ethics that govern you as a dental professional. It specifies the principles, standards and guidance which apply to all members of the dental team. It also sets out what patients can expect from their dental professionals.'*

The *Business Dictionary* (2017) defines performance as:

> *'The accomplishment of a given task measured against preset known standards of accuracy, completeness, cost, and speed'.*

It seems to me that this is getting closer to defining performance for dental professionals. I'm going to take the definition apart a little further.

**Task**: The performance of an aspect of dentistry, be that clinical or non-clinical. For this example, I will use a new patient examination (Table 1.1).

I think we are getting closer to what performance includes. However, the example above shows largely human factors relating to a specific individual. Performance is wider than the single individual undertaking a task; other factors or variables affect the ability of an individual to perform any given task at any given time. The personal characteristics of the dental professional will affect their ability to undertake tasks. I will cover character in Chapter 3. In the case of a clinician, this ability is

**Table 1.1** Mapping a new patient examination to the *Business Dictionary* definition.

| Criteria | Preset known standard |
|---|---|
| Accuracy | FGDP (UK) Clinical Examination |
| Completeness | Examination of hard tissues, soft tissues (intra- and extraoral) |
| | Full history to include dental, medical, personal and sociobehavioural |
| | Reason for attendance/attitude to dental health |
| | Special investigations |
| Cost | Unit of Dental Activity (UDA) value. NHS Band 1 (as at 16 August 2017) £20.60 |
| Speed | 10–15 minutes |

compounded by factors relating to the individual patient. I will go into more detail about external factors in Chapter 2. In addition to the personal characteristics of the professional and patient, there are other external factors, for example the environment and context in which work is undertaken.

Another point to remember is that the performance of any one professional can never be wholly good or wholly poor. If everything dental professionals do is a performance, then some things will be undertaken to a higher level or a poorer level of performance than others. It is interesting to ponder which aspects of performance are more likely to be interpreted by our patients as poor.

In their dental advice series *Handling Complaints England*, Dental Protection Ltd (2016) states:

> *'Communication skills, and in particular non-verbal skills, significantly affect a patient's satisfaction level towards outcomes of treatment. Providing patients with extra time during treatment changes their perception of the level of care provided. Research shows that patients are more likely to sue if they feel rushed and that insufficient time has been spent with them.'*

It is not really surprising that patients are more likely to judge their care on the non-clinical aspects of the dentistry they experience. However, dental professionals can often underestimate how important these aspects are to patients. Patients expect their dental professionals to be clinically competent, of course. They do not expect to be treated without respect, courtesy or to feel unduly rushed.

In their research into public attitudes to dental standards, Costley and Fawcett (2010) found that:

> *'The most significant issue relating to standards that arose from these discussions was that of communication. Communication is important in its own right. Moreover, it appears to underpin every other issue and concern arising in the discussions and its importance cannot be overemphasised in the standards review.'*

Communication is a subject that includes an array of subtle factors. Poor communication features in many of the cases heard by GDC fitness to practise panels. Chapter 3 will consider communications in greater detail.

Having briefly considered what performance is, I will now turn to think about poor performance.

## What is poor performance?

As I have noted previously, performance is what we do every day as dental professionals. You perform whether you are clinical or non-clinical, general dental practitioner or dental public health consultant, full-time researcher or indemnity adviser. It's what professionals do – they perform. I do not use the terminology in any way to suggest a lack of integrity or reduced authenticity.

If performance is what dental professionals do, what is poor performance? A little simplistic maybe, but it is performing at less than the acceptable standard as expected by our commissioners and professional regulators, the CQCand the GDC. Ethically and morally, I think poor performance can also be considered as working below what is expected in providing a safe, acceptable standard of care for patients. If you no longer work clinically with patients then the standard is what is expected of the role you occupy or by your employer or commissioner. However, there is more to the GDC nine principles than clinical care and all registrants must meet the principles.

The National Clinical Assessment Service (2010) has a helpful definition of poor performance.

> *'Any aspects of a practitioner's performance or conduct which:*
> - *pose a threat or potential threat to patient safety;*
> - *expose services to financial or other substantial risk;*
> - *undermines the reputation or efficiency of services in some significant way;*
> - *are outside acceptable practice guidelines and standards.*
>
> *Any performance concern has the potential to impact on patient safety or impinge on the wider public interest so the particular circumstances and*

> *risks associated with each case must be systematically evaluated. Performance concerns may relate to a single area of concern or be multi-factorial. Areas of concern include clinical errors, knowledge or skill deficits, outdated forms of practice, inappropriate attitudes/behaviour or conduct, dishonesty and other unlawful activity, poor interpersonal communication, as well as health and addiction problems.'*

This is a useful definition of poor performance. It shows that the term encompasses a breadth of issues and also hints at the complexity of poor performance. The range is considerable; in my experience, concerns are rarely simple even if they appear so when they first come to notice.

How does poor performance develop? If we knew the answer to that question with certainty, then prevention would be so much more straightforward. Sadly, reliable crystal balls are hard to come by. However, I think the quote below goes some way towards an explanation.

> *'The things we have done in the past become our future.'* (Te Ao Pehi Kara, Maori spiritual expert, Tokanaga)

I came across this quotation when visiting the Wellington Museum on a trip to New Zealand and it resonated strongly with me. It seems to me that often poor performance is the result of a slow accumulation of 'just below par' ways of working, each building on the last until eventually the performance exhibited by an individual is poor and unacceptable. It is a slow descent down a slippery slope almost imperceptible on a day-to-day basis. As the quotation suggests, what we did yesterday and today will become our future. Of course, there are also the one-off events that occur. These can often be serious. Interestingly, I think that the one-off serious issue can be dealt with more quickly and successfully than the slow descent. Possibly the reason is that one-off issues are more visible than the slide.

The document *Handling Concerns about the Performance of Healthcare Professionals* (NCAS, 2006) included a list of concerns that define poor performance.

- Low standard of work; for example, frequent mistakes, not following a task through, inability to cope with instructions.
- An inability to handle a reasonable volume of work to a required standard.
- Unacceptable attitudes to patients.
- Unacceptable attitudes to work or colleagues, for example, unco-operative behaviour.
- Poor communication, inability to acknowledge the contribution of others.

- Poor teamwork, lack of commitment and drive.
- Poor punctuality and unexplained absences.
- Lack of skills in tasks/methods of work required.
- Lack of awareness of required standards.
- Consistently failing to achieve agreed objectives.
- Acting outside limits of competence.
- Poor supervision of the work of others when this is a requirement of the post.
- A health problem.

If this is a list of concerns, then perhaps the reverse will shed light on what satisfactory or good performance includes, for example a good awareness of required standards, only acting within limits of competence and handling a reasonable volume of work to a required standard. The list may also illuminate which aspects of performance are more likely to be unacceptable to patients. These will probably include those non-clinical skills such as unacceptable attitudes to patients and poor communication raised by Costley and Fawcett (2010).

> *'There are three rules you should live by. Be on time. Learn your lines. Don't be a dick. It boils down to respecting people's integrity and choices, being professional and accepting you are not the centre of the universe.'*
> (Interview with Fionn Whitehead, actor, 2016)

I really liked this quote when I read it; it seemed to me that it has resonance for all dental professionals. In fact, I liked it so much that I mapped it into the nine GDC professional standards (Table 1.2), just to help me think it through.

Perhaps if the GDC adopted the rules from Fionn's quote, dental professionals would find it easier to remember the basic tenets of the service we provide. This may seem rather a 'tongue in cheek' comment, but I hope it will be taken in the spirit I intend, using humour to make a serious point.

Every dental professional will experience difficulties, every dental professional will make mistakes. It's not the difficulty or the mistake that really matters, it's what the individual does next that proves their mettle. Those who are humble in knowing themselves, recognise when their performance dips and do something about it will move forward stronger. Those who are arrogant and ignore their mistakes or don't even appreciate they have made mistakes are much more likely to experience a regulatory investigation. Unfortunately, this is not as simple as it might at first appear. Later, in Chapter 8, I will be considering the work of Kruger and Dunning (1999) and their findings in the field of insight.

**Table 1.2** Mapping the GDC professional standards to Fionn Whitehead quote.

| Quote rules | Fionn's interpretation | GDC standard |
|---|---|---|
| Be on time | Respecting people's integrity and choices | Put patients' interests first<br>Obtain valid consent<br>Maintain and protect patients' information |
| Learn your lines | Being professional | Communicate effectively with patients<br>Maintain, develop and work within your professional knowledge and skills<br>Raise concerns if patients are at risk |
| Don't be a dick | Accepting you are not the centre of the universe | Have a clear and effective complaints procedure<br>Work with colleagues in a way that is in patients' best interests<br>Make sure your personal behaviour maintains patients' confidence in you and the dental profession |

## Fitness to practise

Here I will briefly add some preliminary thoughts about fitness to practise, which is covered in more detail in Chapters 4 and 6.

Fitness to practise is an overarching concept which includes a number of aspects. A dental professional who is fit to practise is able to provide dental services, care and treatment safely and effectively to others in society. This includes the professional's ability to undertake procedures and interventions – that is, their clinical ability and competence, skill, knowledge and expertise. It also includes behaviour and character traits demonstrated in both the practising environment and outside.

Sometimes when you become involved with performance or fitness to practise processes, it can seem easier to ignore the issues and tell yourself they will go away on their own. This can be a reaction that is hard to resist but it is a strategy that rarely if ever works. It is the same whether you are the registrant about whom there has been a complaint or if you become involved in proceedings. I have worked with a number of registrants who have ignored letters from the GDC and done nothing, sometimes even to the point of a hearing being conducted in their absence. Once an issue has been flagged, it will progress, regardless of whether the registrant engages with the process or not. Refusal to co-operate and engage with the fitness to practise mechanisms does little to predispose the GDC panel toward your case. It can be difficult, but doing nothing and turning away will not work.

## Red door/green door

Referral to the GDC generally follows one of three pathways.

1. No substance, no case to answer.
2. Some or all of the complaint has substance. The professional accepts that, recognises the wake-up call and uses the process to improve their practice, emerging from the situation bruised but a better professional.
3. Some or all of the complaint has substance. The professional refuses to recognise or appreciate this and rails against the complaint and the GDC. This approach can result in a very poor outcome for the professional.

The GDC lays considerable store on registrants demonstrating 'insight'. Where insight is absent or poorly demonstrated, it shows that the individual is unable to detect that a problem has occurred. Their self-awareness is so low that they believe their practice or attitude or behaviour is acceptable and change is unnecessary. Occasionally, self-awareness and insight are at such a low level that the individual may actually think their performance is good and everyone is against them. In cases where insight is minimal or absent, the GDC cannot feel assured that the issues or failures will not be repeated. Hence the outcome is likely to be harsher, sometimes severe.

Those registrants who follow route 3 can face the Red Door, which opens onto the world outside dentistry. Step through the Red Door and you are no longer able to call yourself a dental professional. You have been erased from the Dental Register. All that training and education gone for ever. Your lifestyle changed for ever. You are an ex-dental professional. It seems unbelievable that this should be a choice for any dental professional and yet, so many contribute to their own passage through the Red Door. Is this arrogance, stupidity, a certain belief in their own rightness? It's difficult to tell. Occasionally, I use a coaching technique where the coach takes the coachee to a future place, in this case to think about a life outside dentistry. What would that look like? How would it feel? What would your lifestyle be? Would your relationship with your spouse and children change? Sometimes, this technique can be the jolt needed and reality is glimpsed. I believe that insight and self-awareness are so important I have devoted Chapter 8 to the subject.

Errors occur in healthcare literally all the time. Dentistry is no different. We dental professionals all make mistakes regularly. If you don't think you do then my response to you is 'Yes you do, although you may not have sufficient insight to realise you do'. If you make a mistake, realise you have made a mistake and learn from it, then you are on the road to being a successful

practitioner. I'm not excusing mistakes, particularly those that directly harm patients; mistakes cost money and money is scarce. Most mistakes or errors are underpinned by a multitude of factors, perhaps the most significant being the human, the dental professional.

The Dental Defence Union (2015) reported a 110% increase in clinical negligence claims between 2011 and August 2015, with rises of 10% each year. Patient expectations may be a factor in this increase. Ensuring that patients are fully aware of what their treatment entails can help to encourage realistic patient expectations. This is part of good communication and it underpins informed consent. Discussions with patients should always include risks, outcomes and consequences. This is particularly important in the case of cosmetic interventions.

When thinking about the performance of dental professionals, it can be interesting to consider the expressed level of satisfaction which patients report. The King's Fund (2017) published data showing that the level of public satisfaction with NHS dentistry is up to 61%. This is an increase of 7% since 2015 and the highest level of satisfaction since the early 1990s. The underpinning data are taken from the British Social Attitudes Survey

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